DOCUMENT RESUME

ED 308 456 CG 021 798

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TITLE Differentiation between Bulimia and Food Addiction in a Community Sample.
PUB DATE Mar 89
NOTE 10p.; Paper presented at the Annual Meeting of the Southwestern Psychological Association (35th, Houston, TX, April 13-15, 1989).
PUB TYPE Reports - Research/Technical (143) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Bulimia; *Disease Incidence; *Eating Habits; Hotlines (Public); *Obesity; Physical Health; Public Health
IDENTIFIERS *Eating Disorders; *Food Addiction

ABSTRACT

Most studies of bulimics have used an identified, clinical sample of individuals who have been evaluated and diagnosed by professional mental health workers. In this study, self-reported food addicts completed a questionnaire that assessed demographic as well as behavioral and cognitive factors related to their eating. The intent was to describe the characteristics of a large community sample of persons with compulsive eating disorders, as well as to describe demographic and behavioral differences between bulimics and compulsive overeaters or food addicts who generally are obese. Data were collected through the Food Addiction Hot Line, a national referral and information source advertised to compulsive eaters which referred callers to Overeater's Anonymous and sent them a packet of information about food addiction and compulsive eating and a data-collection survey. Approximately 11,000 calls have been logged, with more than 2,500 surveys returned. Except for differences in the incidence of purging or other abnormal weight-control methods, the sample was homogeneous. Most respondents were obese, worried about their weight and shape, had out-of-control eating, ate refined carbohydrates in binges, and usually had binges more than once a day. Although most individuals would not be diagnosed as bulimic, they suffered from similar compulsive eating disorders. The data reflect a real public health issue that needs to be addressed. (ABL)

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Differentiation between Bulimia and Food Addiction in a Community Sample

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Most studies of bulimics have used an identified, clinical sample who have been evaluated and diagnosed by professional mental health workers (*e.g.*, Pyle, Mitchell and Eckert, 1981). A few studies have looked at prevalence of the disorder in a community sample, usually drawn from university student populations (*e.g.*, Stangler and Printz, 1980). One rationale for the latter tactic, is the expectation that bulimia is most likely to be found within the age group represented in universities. In the present study, we were interested in identifying potentially bulimic individuals with another sampling method that appealed broadly to compulsive overeaters. Our goal was to create a large community sample that was broadly representative of the national population of bulimics, rather than narrowly formed from sub-groups such as college students. In doing so, we felt that we could shed light on demographic, behavioral and cognitive issues in bulimia as well as begin a deeper analysis of the relationship among the various categories of these variables.

One rationale for the study was disparity in recent reports on the prevalence of bulimia. Some popular reports said that compulsive eating disorders such as bulimia were reaching epidemic proportions in the general population (Squire, 1983). Some subsequent articles in the professional literature have described prevalence levels in the one to five per cent range (Hart and Ollendick, 1985 and Healy, Conroy and Walsh, 1985). A major issue in such disparities is definitional. Hart and Ollendick and Healy *et al.* adhered rigidly to DSM-III criteria for bulimia. Other authors have used binge eating as evidence of bulimia without much regard to the other factors that are keys to the clinical diagnosis. Since binge eating often characterizes obese and anorexic individuals, failure to use clear or consistent criteria for diagnosis or classification has the potential to cause confusion in clinical settings as well as in the research literature.

In the present study, self-reported food addicts completed a questionnaire that assessed demographic as well as behavioral and cognitive factors related to their eating. It was our intent to describe the characteristics of a large community sample of persons with compulsive

Presented at the 35th annual meeting of the Southeastern Psychological Association, March, 1989, Washington, DC

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eating disorders, as well as to describe demographic and behavioral differences between bulimics and compulsive overeaters or food addicts who generally are obese. Since questions that would suggest confirmation or elimination of a diagnosis of Bulimia Nervosa as found in DSM-IIIR were included in the survey, we also analyzed possible differences in diagnosis that could vary with the stringency of adherence to those criteria.

METHOD

The present data were collected through the Food Addiction Hot Line, a national referral and information source advertised to compulsive eaters (Webbe, 1988). More than 300 media sources nationwide - newspaper, magazine, radio and television - have run public-service announcements publicizing the Hot Line. These sources include the Washington Post, the Atlanta Constitution and Journal, Boston radio station WBZ, New York television station WABC, Cosmopolitan magazine, Ladies Home Journal and the National Enquirer. Callers are referred to local chapters of Overeater's Anonymous, sent a packet of information about food addiction and compulsive eating and a data-collection survey. In a cover letter with the packet, the callers are asked to complete the survey for research purposes and to return it in the stamped, addressed envelope that is enclosed. Addictions counselors are available to return calls. All services are provided free of charge. Approximately 11,000 calls have been logged to date, with more than 2,500 surveys having been returned. The presesnt results are based upon analysis of the initial 500 returned surveys. What is reported here is part of the descriptive analysis of these data that Joanne Clontz has used in her master's thesis.

RESULTS

Eighty-seven per cent of respondents believed that their eating patterns were abnormal. Ninety-five per cent had poor self image because of their overeating and 89% were often depressed because of their eating problems. For most of the subjects, overeating was not a new problem. Most had lived with this for more than 10 years, and nearly half for more than 20.

Only 25% of the respondents had ever been in some kind of treatment, and for most of these it had been Weight watchers or an analogous non-professional group. Only 6% of the subjects ever had been formally diagnosed as bulimic.

Eighty-one per cent of the respondents admitted eating in binges, and, typically, had been doing so for longer than one year. Three to four binges per day were most common. Ninety two per cent of the respondents who reported binge eating said that their binge foods of choice were refined carbohydrates. The primary response of respondents to their binging was to diet. Over 80% had gained or lost large amounts of weight on a regular basis. Only 21% induced vomiting. Larger percentages used diuretics and laxatives, and many reported using

exercise to control weight, but the interpretation of exercise amount needs some care, particularly in a mail survey.

Using a very strict interpretation of the DSM-IIIR criteria for Bulimia Nervosa, about 40% of the respondents would likely be so diagnosed . The criteria are shown in Table 1. Generally, most subjects fit four of the five criteria, but did not clearly involve themselves in a pathological adjusting response to their binging. They binged, felt they had no control over eating during binges, binged at least twice per week and were very concerned with body shape and weight, however, they did not vomit, use diuretics, laxatives or otherwise engage in a purging-type behavior.. Criteria related to "...regularly engaging in...strict dieting and fasting..." are also difficult to interpret by mail, and could have resulted in more respondents achieving the diagnosis.

Most of the respondents were obese, with current weights being at least 50% higher than the ideal weight, based upon height and body build. Generally, those individuals who were likely to be bulimic according to all criteria were closest to a normal weight. The more obese people generally did not meet strict criteria for bulimia.

Ten per cent of the returned surveys were from men. This was higher than we had expected and much higher than reported in previous surveys that targeted bulimic populations only (Fairburn and Cooper, 1982; Johnson, Stuckey, Lewis and Schwartz, 1982). The median age of the men was 45, with a range of 12 to 76. The median age of the women was 38, with a range of 11 to 82. Previous studies with bulimic populations have reported median ages in the low twenties for their primarily female sample.

Thirty-four per cent of the respondents had given up hope of overcoming their eating problems. Almost 15% of all who responded had attempted suicide at least once. In addition to this direct self-destructive behavior, more than 70% of the respondents also reported significant health problems associated with their overeating or pathological weight control tactics, primarily high blood pressure and heart disease, arthritis, kidney disease and back disorders.

DISCUSSION

Except for differences in the incidence of purging or other abnormal weight-control methods, our sample was very homogeneous. Most were obese, they worried about their weight and shape, they had lost control over eating, they ate refined carbohydrates in binges, and the frequency of their binges was usually greater than one per day. Many reported that they had attempted to induce vomiting but had been unsuccessful. They had dieted and fasted as a major attempt to control weight. Thus, although most of these individuals would not be diagnosed as bulimic, they suffered from similar compulsive eating disorders. It remains to be seen whether

or not these individuals would differ on a scale that examined the pathological severity of their over eating or of correlative behaviors.

An interesting thing that we learned in the course of this analyis was the ease with which the diagnostic criteria for bulimia nervosa could be manipulated. Even without a patient in a face to face interview, answers to diagnostically relevant questions could be stilted, particularly if the evaluator was highly motivated to identify bulimics. It seems very like;y, that with a patient physically present for intake and evaluation, diagnoses of bulimia could be made for most cases of compulsive overeating. Items related to dieting and fasting are very noteworthy in this regard (*cf.* Willmuth, Leitenberg, Rosen and Cado, 1988).

We feel that the present data reflect a real public health issue that needs to be addressed immediately and aggressively. Given that many respondents were in their fifties, sixties and seventies and said that their problems with food were life-long, medical complications associated with food addiction clearly could be expected to take a toll on individual, and by implication, societal productivity. Only 30% of all the people who returned our survey had ever been in any kind of treatment, and these primarily were Weight-Watchers or other non-professional programs. Clearly, there is a population out there waiting for treatment.

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Table 1

Diagnostic Criteria for Bulimia Nervosa (DSM-IIIR)

1. Recurrent episodes of binge eating (rapid consumption of a large amount of food in a discrete period of time.
2. A feeling of lack of control over eating behavior during the eating binges.
3. The person regularly engages in either self-induced vomiting, use of laxatives or diuretics, strict dieting or fasting, or vigorous exercise in order to prevent weight gain.
4. A minimum of two binge eating episodes a week for at least three months.
5. Persistent overconcern with body shape and weight.

Table 2

Demographic Information on 500 Food Addicts

Gender:	Male = 10% Female = 90%
Age:	<20 = 8% 21-30 = 21% 31-40 = 31% 41-50 = 20% 51-60 = 12% >60 = 9%
Race:	Caucasian = 90% African American = 6% Hispanic = 3%
Marital status:	Married = 48% Single = 33% Divorced = 17%
Occupation:	Housewife = 18% (by far the most frequent)
Education level:	<12 = 9% 12 = 34% 13-15 = 33% 16 = 16% >16 = 8%
Family income:	<10K = 30% 11K-20K = 19% 21K-40K = 31% 41K-60K = 13% >60K = 8%

Table 3
Food and Eating-related Information

General

Feel that their pattern of eating is abnormal:		87%			
Feel badly about self because of eating problem:		95%			
Felt depressed because of eating problem:		89%			
Dissatisfied with body shape:		56%			
Years that eating has been a problem:	<1 = 4%	1-5 = 15%	6-10 = 16%	1-20 = 26%	>20 = 40%
Eat in binges:		81%			
No control during a binge:		87%			
Binge on refined carbohydrates:		92%			

Pathological response to overeating

Manually induced vomiting:	21%
Cathartic use:	6%
Diuretic use:	34%
Laxative use:	35%
Vigorous exercise:	39%
Extensive fasts:	40%
Excessive dieting:	83%

Treatment information

Been in treatment for eating problem:	25% (includes non-professional approaches)
Outpatient treatment:	83%
Inpatient treatment	17%
Previously diagnosed as bulimic	6%

Substance use

Smoke cigarettes:	18%
Drink alcohol:	39%
Admit alcohol abuse:	2%
Use other substances:	17%
Other family members who are addicted:	55%

Affective and self-destructive sequelae

Given up hope of eating normally:	34%
Self destructive acts:	8%
Attempted suicide:	15%